Supreme Court, U.S.
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In the

Supreme Court of the United States

Sidney Esensten; Jeffrey A. Arenson; Family Medical Clinic, P.A., a Minnesota Non-Profit Corp.; Fairview, a Minnesota Non-Profit Corp.,

Petitioners,

v.

Dianne L. Shea,

Respondent.

ON PETITION FOR WRIT OF CERTIORARI
TO THE UNITED STATES COURT OF APPEALS
FOR THE EIGHTH CIRCUIT

RESPONDENT'S BRIEF IN OPPOSITION

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QUESTION PRESENTED

DID THE EIGHTH CIRCUIT CONTRADICT THE DECISIONS OF THIS COURT IN FINDING THAT ERISA DOES NOT PREEMPT THE HIPPOCRATIC OATH?

TABLE OF CONTENTS

QUESTION PRESENTED i

TABLE OF CONTENTS ii

TABLE OF AUTHORITIES iii

REASONS FOR DENYING THE WRIT 1

I. THIS COURT LACKS JURISDICTION TO DECIDE THE ISSUES PRESENTED IN *SHEA I* 2

II. THE EIGHTH CIRCUIT'S DECISION FAITHFULLY APPLIES THIS COURT'S NARROW ERISA PREEMPTION TEST IN AN UNCONTROVERSIAL FASHION 3

III. PETITIONERS HAVE MISSTATED THE FACTS 8

A. MEDICAL HISTORY 9

B. UNDISCLOSED MANAGED CARE INCENTIVES 13

C. THE MATERIALITY OF DISCLOSURE 16

D. THE ETHICAL AND PROFESSIONAL MANDATE TO DISCLOSE 18

CONCLUSION 21

TABLE OF AUTHORITIES

Cases

California Division of Labor Standards v. Dillingham, 117 S. Ct. 832 (1997) 5

DeBuono v. NYSA-ILA Medical and Clinical Services Fund, 117 S. Ct. 1747 (1997) 4, 5

In re Home Health, Inc. v. The Prudential Insurance Co. of America, 101 F.3d 600 (8th Cir. 1996) 5

New York State Conference of Blue Cross & Blue Shield Plans v. Travelers Insurance Co., 514 U.S. 645 (1995) 1, 3, 4, 6

Matsushita Electric Industrial Co. v. Zenith Radio Corp., 475 U.S. 574 (1986) 8

Pegram v. Herdrich, 503 U.S. __, No. 98-1949, slip op. (U.S. June 12, 2000) 1, 7, 8

Shea v. Esensten ("Shea I"), 107 F.3d 625 (8th Cir.), *cert. denied*, 522 U.S. 914 (1997) ..... *passim*

Shea v. Esensten ("Shea II"), 208 F.3d 712 (8th Cir. 2000) ..... *passim*

Wilson v. Zoellner, 114 F.3d 713 (8th Cir. 1997) 5

Statutes and Rules

29 U.S.C. § 1144(a) 3

Sup. Ct. R. 15.2 2

Secondary Authorities

Michael E. Cafferky, MANAGED CARE & YOU (1995) .. 15

Catherine L. Fisk, *The Last Article About the Language of ERISA Preemption? A Case Study of the Failure of Textualism*, 33 HARV. J. ON LEGIS. 35 (1996) 6

REASONS FOR DENYING THE WRIT

The District Court granted summary judgment preempting Mrs. Shea's State-law fraud and punitive damages claims against the Petitioner doctors. These claims were, in turn, premised on the professional obligations of doctors to disclose affirmatively a financial conflict of interest. Such obligations can be traced to ancient ethical canons and to development over the last generation of the doctrine of informed consent; doctors, in short, have fundamental duties of loyalty and disclosure that require them to advise their patients of a financial incentive against making a necessary specialist referral. In reversing this preemption ruling, the Eighth Circuit applied the precedents of this Court to reach the unsurprising conclusion that ERISA does not preempt the Hippocratic Oath. The duty of a treating physician to disclose a financial conflict remains an issue of State law and was never intended by Congress to be preempted by ERISA. The Court need not grant the writ to reaffirm the obvious.

The Petition solicits the interest of this Court (1) by positing issues not before it; (2) by misconstruing a rich body of recent decisions of this Court that have in fact considerably narrowed the scope of ERISA preemption; and (3) by misstating the facts of this case. In particular:

First, this Court has already declined to review the 1997 holding of the Eighth Circuit (*"Shea I"*) that ERISA preempts disclosure claims against ERISA plan administrators. The issues presented in *Shea I* cannot be resurrected now. Nor is there any reason to resurrect those issues given the consistency of both *Shea I* and the decision at bar (*"Shea II"*) with the Court's recent decision in *Pegram v. Herdrich*, 503 U.S. ___, No. 98-1949, slip op. (U.S. June 12, 2000)

Second, beginning with its decision in *New York State Conference of Blue Cross & Blue Shield Plans v. Travelers Insurance Co.*, 514 U.S. 645 (1995), and most recently in its June 2000 *Pegram* decision, this Court has applied a

pragmatic test to determine whether preemption is necessary to serve the purposes of ERISA. The connection with ERISA urged in support of preemption here is far too remote and peripheral to serve any bona fide ERISA purpose. It is clear that the Petitioner doctors themselves are not ERISA entities or fiduciaries and that the source of their duty to disclose has everything to do with traditional subjects of State law and nothing to do with ERISA.

By happenstance, the source of the conflict of interest was an HMO-Clinic contract that, in turn, governed medical care paid for by an ERISA plan set up by Mr. Shea's employer. Had the source of the conflict been the doctors' interest in an Indian gambling casino, no one would have been so bold as to claim preemption. In ERISA, as in other areas of law, rulings flow from logic or practical experience, not from happenstance. The Eighth Circuit has correctly applied the ERISA preemption decisions handed down by the Court since 1995. Its decision is too straight-forward, and the preemption law is too well-developed, to merit additional review by the Court.

Third, the Petitioners' statement of facts, the premise of which is that they rendered "perfect" medical care, cannot go unchallenged. *See* Sup. Ct. R.15.2. Apart from presenting the paradox that perfection kills, such a recitation ignores the procedural posture of the case. The preemption issue was presented via a summary judgment motion by the Petitioners; the facts must therefore be viewed in a light most favorable to Mrs. Shea.

I. THE COURT LACKS JURISDICTION TO DECIDE THE ISSUES PRESENTED IN *SHEA I*.

The present case has produced two Eighth Circuit decisions. The first decision held that ERISA ***did*** preempt a claim that the ERISA ***plan administrator*** (Medica) has a duty

to disclose physician incentive schemes that paid a bonus for denying specialist referrals and that exacted a penalty for granting such referrals. The Eighth Circuit further found that ERISA would allow a remedy for the wrong on a breach of fiduciary duty theory. Because Mrs. Shea preferred a State common law remedy, she contested the preemption ruling and petitioned this Court for certiorari. The Court denied the petition in October, 1997. *See Shea v. Esensten*, 107 F.3d 625 (8th Cir.), *cert. denied*, 522 U.S. 914 (1997) ("*Shea I*").

The second decision held that duty-to-disclose claims against non-plan fiduciary treating physicians are not preempted by ERISA. *Shea v. Esensten*, 208 F.3d 712 (8th Cir. 2000) (*Shea II*). This is the only decision that is before the Court. Much of the Petition is directed at the perceived inconsistency and inequity of preempting disclosure claims against plan administrators, on the one hand, and allowing a State tort remedy to stand against non-plan fiduciary doctors for failing to disclose, on the other. Such contentions are irrelevant given that this Court has already declined to review the former decision; they are better made to the Eighth Circuit in the form of a petition for rehearing, an option that Petitioners waived.

II. THE EIGHTH CIRCUIT'S DECISION FAITHFULLY APPLIES THIS COURT'S NARROW ERISA PREEMPTION TEST IN AN UNCONTROVERSIAL FASHION.

ERISA preempts State laws, including State tort suits, that "relate to" an ERISA plan. 29 U.S.C. § 1144(a); ERISA § 514. The scope of ERISA preemption is a pure issue of law reviewed de novo by an appellate court.

The Court has recently repudiated broad, literal constructions of the "related to" language of the preemption statute, given that, logically, relations stop nowhere. *Travelers*, 115 S. Ct. at 1677. "We simply must go beyond

the unhelpful text and frustrating difficulty of defining its key term, and look instead to the objectives of the ERISA statute as a guide to the scope of the state law that Congress understood would survive." *Id.*

Because Congress intended to preserve the "historic police powers of the State includ[ing] the regulation of matters of health and safety", those seeking to preempt the State's exercise of such powers "bear[ ] the considerable burden of overcoming 'the starting presumption that Congress does not intend to supplant state law.' *Travelers*, 514 U.S., at 654...." *DeBuono v. NYSA-ILA Medical and Clinical Services Fund*, 117 S. Ct. 1747, 1751 (1997). Consequently, ERISA does ***not*** preempt a "'myriad of state laws' of general applicability that impose some burdens on the administration of ERISA plans but nevertheless do not 'relate to' them within the meaning of the governing statute." *DeBuono*, 117 S. Ct. at 1752.

The Eighth Circuit previously found in this case that claims for fraudulent nondisclosure of financial incentives ***against the ERISA plan administrator*** are preempted by ERISA. *Shea I*, 107 F.3d 625. The Eighth Circuit further recognized that ERISA provides the sole remedy for a breach of this fiduciary duty. *Id.* This claim was resolved below, and Medica, the ERISA plan administrator, has been dismissed from the case.

By contrast, the preemption issue presented now is whether ERISA preempts claims of fraudulent nondisclosure of financial incentives against the non-plan fiduciary ***doctors*** themselves. Unlike Medica, the ***doctors'*** disclosure duties are not governed by ERISA; their duties are instead governed by ancient professional and ethical canons that predate ERISA by a millennium and that are the very stuff of traditional State law. Because there is absolutely no evidence of congressional intent in enacting ERISA to nationalize medicine and medical ethics – indeed, this was an option expressly rejected by Congress – ERISA preemption would serve no bona fide

ERISA purpose. Defendants cannot, therefore, overcome *DeBuono's* heavy presumption against preemption of the states' traditional police powers over matters of health and safety.

Whether ERISA preempts malpractice and fraud claims against a ***doctor*** (i.e., a non-plan fiduciary service provider to an ERISA plan) is neither governed by nor is it inconsistent with *Shea I.* Instead, the preemption rule in *Shea II* is a simple extension of the Court's holding in *California Division of Labor Standards v. Dillingham*, 117 S. Ct. 832 (1997). In *Shea II,* the Eighth Circuit applied the *Dillingham* rule via the two-pronged preemption test it had previously announced in *Wilson v. Zoellner*, 114 F.3d 713 (8th Cir. 1997). The first prong consists of determining whether the state law at issue made "reference" to ERISA plans. That is, did it act "immediately and exclusively upon ERISA plans"?; alternatively, was the "existence of ERISA plans ... essential to the law's operation"? *Wilson*, 114 F.3d at 716. If so, the state law was per se preempted.

A fraudulent misrepresentation claim against a doctor does not act exclusively upon ERISA plans nor is the existence of an ERISA plan essential to the tort. HMO incentives are not unique to ERISA plans and operate independently from ERISA plans. The doctors' duty to disclose such incentives is of general application and does not actually or implicitly refer to ERISA plans. Hence, the tort is not preempted under the first prong of the *Wilson-Dillingham* test.

The second prong of the test asks whether the state law to be preempted has an impermissible "connection" with an ERISA plan. *Wilson,* 114 F.3d at 717. This test is narrowly applied with an eye toward the underlying objectives of ERISA. *Id.; see also In re Home Health, Inc. v. The Prudential Insurance Co. of America*, 101 F.3d 600, 606 (8th Cir. 1996) ("The 'ultimate touchstone' in deciding whether ERISA preempts a state law is the Congressional purpose in

enacting ERISA"); Catherine L. Fisk, *The Last Article About the Language of ERISA Preemption? A Case Study of the Failure of Textualism*, 33 HARV. J. ON LEGIS. 35 (1996).

Using ERISA preemption to preserve the uniformity of the disclosure obligations of a plan administrator can be said to serve a bona fide ERISA purpose. In *Shea I*, the Eighth Circuit reasoned that forcing plan administrators to follow 50 different disclosure laws would contradict Congress' intent to ensure the "nationally uniform administration of employee benefit plans." *Id.*, 107 F.3d at 627.

This reasoning has no application when the party charged with a duty to disclose is not a plan administrator and when the duty to disclose is grounded in notions of informed consent and professional standards that pre-date ERISA and that have always been governed by State law. To be sure, this means that doctors in different States who contract with the same plan may have different disclosure obligations. But plan administrators already contract with doctors knowing that their licensure and professional obligations are governed by 50 different State systems. Even the Petitioner doctors concede that the interest in uniformity is not so compelling as to require the federal courts to nationalize the law of medical malpractice. The Doctors' disclosure obligations are simply one subset of State malpractice law; there is no reason to single out this subset for preemption.

In short, the Eighth Circuit decisions and *Shea I* and in *Shea II* comport with the pragmatic and functional preemption test announced by the Supreme Court in *New York State Conference of Blue Cross & Blue Shield Plans v. Travelers Insurance Co.*, 514 U.S. 645 (1995). Preempting the disclosure duties of a plan administrator can be said to serve the ERISA purpose of making the disclosure duties of plan fiduciaries uniform; preempting the professional and ethical duties of doctors to disclose conflicts to their patients serves no such purpose.

None of this was changed by the Court's June 2000 *Pegram* decision. There the Court held that mixed treatment and eligibility decisions by HMO physicians are not fiduciary decisions under ERISA, and therefore do not state an ERISA claim. The case did ***not*** even present a preemption issue. Moreover, the Court based its ruling in part on its fear that recognizing such a broad ERISA claim would result in the very absurdity urged here by the Petitioner doctors: the misuse of ERISA to preempt claims against doctors.

> The mischief of Herdrich's position would, indeed, go further than mere replication of state malpractice actions with HMO defendants. For not only would an HMO be liable as a fiduciary in the first instance for its own breach of fiduciary duty committed through the acts of its physician employee, but the physician employee would also be subject to liability as a fiduciary on the same basic analysis that would charge the HMO.... Hence, the physician, too, would be subject to suit in federal court applying an ERISA standard of reasonable medical skill. This result, in turn, would raise a puzzling issue of preemption. On its face, federal fiduciary law applying a malpractice standard would seem to be a prescription for preemption of state malpractice law, since the new ERISA cause of action would cover the subject of a state-law malpractice claim.... We could struggle with this problem, but first it is well to ask, again, what would be gained by opening the federal courthouse doors for a fiduciary malpractice claim, save for possibly random fortuities such as more favorable scheduling, or the ancillary opportunity to seek attorney's fees. And again, we know that Congress had no such haphazard boons in prospect when it defined the ERISA fiduciary, nor such a risk to efficiency of

federal courts as a new fiduciary-malpractice jurisdiction would pose in welcoming such unheard-of fiduciary litigation.

The Petitioner Doctors protest that *Shea I*'s recognition of an ERISA claim against an HMO/plan administrator for breach of the fiduciary duty to disclose somehow runs afoul of *Pegram*. However, the Court has already reviewed and declined a petition for certiorari filed from that decision. Moreover, the Court in *Pegram* was careful to note that *Pegram* was not a duty-to-disclose case. *See, Pegram*, slip op. at footnote 8. Accordingly, neither *Shea I* nor *Shea* II contradicts the analysis of *Pegram*.

III. PETITIONERS HAVE MISSTATED THE FACTS.

The Petitioner Doctors have provided the Court with a one-sided, argumentative statement of facts, the thesis of which is that they rendered "perfect" care to the deceased Patrick Shea. Petition for Writ of Certiorari at p. 10.

The Petitioner Doctors, Defendants below, presented the ERISA preemption issue on a motion for partial summary judgment. Given this procedural posture, the facts must be viewed in a light most favorable to Mrs. Shea. *Matsushita Electric Industrial Co. v. Zenith Radio Corp.*, 475 U.S. 574(1986). The test is whether "the record taken as a whole could not lead a rational trier of fact to find for the non-moving party, there is no genuine issue for trial." *Id.* at 586-87.

Mrs. Shea's failure to prevail at a later state court trial of a different medical malpractice theory – involving the duty to refer as opposed to the duty to disclose – is irrelevant for three reasons. First, the theories are different. Second, the state court decision is currently on appeal to the Minnesota Court of Appeals given that, *inter alia*, the trial court refused

to allow Mrs. Shea to impeach the doctors with evidence of HMO incentives against referral. And third, this state court trial occurred after the federal district court granted partial summary judgment slicing up Mrs. Shea's case.

Mrs. Shea relies on the exhaustive statement of facts in her briefs filed with the Eighth Circuit as the proper basis for reviewing the legal issues presented here. The following facts bear repeating.

A. MEDICAL HISTORY.

Plaintiff-Respondent Dianne L. Shea ("Mrs. Shea") is the widow of Patrick Joseph Shea("Mr. Shea"), who died of heart failure at the age of 40 on March 5, 1993. Mrs. Shea is the mother of two children, who were age 14 and 12 at the time of their father's death. Appellant Shea's Eighth Circuit Appendix ("App.") 440-42.

With the exception of diabetes, Mr. Shea suffered from every known risk factor for heart disease. He was a white male smoker, age 40, with high cholesterol and a strong family history of early death from heart disease. He also suffered from chest pain that on one occasion eight months before his death was severe enough to hospitalize him while on business in Thailand. U.S. District Court, D. Minn., Case No. 96-CV-406, Docket No. 158, Ex. J at p. 34 (Dr. Davis deposition), Ex. C (Thai medical records), Ex. D (admission to same).

After he was discharged from the Thai hospital, Mr. Shea immediately returned to Minnesota and made an appointment to see Defendant Dr. Sidney Esensten ("Dr. Esensten") on July 6, 1992. Dr. Esensten had served as Mr. Shea's family doctor for several years. He practiced at the Defendant Family Medical Clinic in Minneapolis, Minnesota (the "Clinic"). App. 429-35.

Mr. Shea had previously consulted with Dr. Esensten on several occasions regarding his family history and cholesterol level sufficiently elevated to manifest itself in cholesterol

plaques that were removed from his eyelids in 1989. At Mr. Shea's insistence, Dr. Esensten's colleague, Defendant internist Dr. Jeffrey Arenson ("Dr. Arenson"), administered a electrocardiograph exercise stress test in February 1992. The test was negative. Dr. Esensten consistently assured Mr. Shea that he was too young and did not have enough cardiac symptoms. App. 40-46, 382-91.

Mrs. Shea was present at the July 6, 1992 appointment. Dr. Esensten was aware that both of Mr. Shea's parents had died of heart disease in their fifties and that Mr. Shea suffered from high cholesterol that had not been resolved by prescription of diet and medication. Despite this, despite all of Mr. Shea's risk factors, despite Mr. Shea's hospitalization in Thailand the previous week for chest pain which the Thai doctor described to Dr. Esensten over the telephone as being angina pectoris, despite his failure to obtain and review the Thai medical records, and despite lacking any expertise in the area of cardiology, Dr. Esensten unequivocally ruled out heart disease. Once again Dr. Esensten advised that Mr. Shea was too young and did not have enough symptoms. He then successfully dissuaded the Sheas from seeking out a second opinion from an expert cardiologist, which they would have done at their own cost. App. 40-46, 433.

The sole basis for Dr. Esensten's diagnosis was that Mr. Shea said he had produced a normal EKG and a normal treadmill test. Dr. Esensten never reviewed the test data from Thailand, though he was aware that Mr. Shea had produced a normal EKG and treadmill test during an examination by Dr. Arenson back in February of 1992. App. 429-35.

In the three months following this fateful July 6, 1992 appointment, Mr. Shea consulted with Dr. Esensten or Dr. Arenson a total of 11 times – on July 6, July 8, July 11, July 22, August 10, August 14, August 18, August 19, August 24, September 10, September 17, and October 6. The medical records characterize Mr. Shea's complaints on these dates as including his hospitalization in Thailand for "SOB [shortness

of breath], dizziness, tightness in his chest"; "belching"; "slight soreness in the left upper quadrant"; "backache"; "distress"; "irritable stomach"; "abdominal pain type symptoms"; "generalized malaise"; "occasional fever"; "occ. dizziness"; "pain in the left side of his adb. after working in his yard; "left upper quadrant pain"; "dizziness, light headedness, sore throat, some rining [sic;] in his ears"; "pain in the left lower quadrant" that is "constant", "dull", and "always there"; "another episode of the light headed, dizzy feeling"; "lower left quadrant abd. pain"; "symptoms in his chest and hands"; "high cholesterol"; "sinus headaches"; a right ear that "buzzes"; "gas and distress on the left side of abdoman [sic]"; and "twitches in the side". U. S. District Court, D. Minn., Case No. 96-CV-406, Docket No. 158, Ex. A (Clinic medical records).

Any abdominal or gastroenterological problem was ruled out by a colonoscopy performed on September 3, 1992. The treating specialist, Dr. Tanghe, characterized the Thai work up and observation as "apparently not conclusive." "At this point, the patient has minimal symptoms, referring to the digestive tract itself," Dr. Tanghe wrote. Dr. Tanghe found no diverticulitis and a "[b]asically normal bowel with no pathology seen to explain patient's symptoms." U. S. District Court, D. Minn., Case No. 96-CV-406, Docket No. 158, Ex. A at pp. 300114-16.

All of which left "hyperventilation" as Dr. Esensten's and Dr. Arenson's diagnosis of Mr. Shea. And the root cause of the hyperventilation was ascribed to "anxiety." However, Mr. Shea denied being anxious and he was never referred for psychological treatment of his "anxiety." App. 381-99, 429-35.

Dr. Arenson claimed he was referred Mr. Shea for a second opinion regarding constant pain in the lower left quadrant of the abdomen. Dr. Arenson claimed he never spoke with Dr. Esensten about the referral. Nor did he undertake a thorough review of Mr. Shea's chart or Mr.

Shea's Thai records. Dr. Arenson's notes did acknowledge a positive family history for coronary disease, and he conceded that Mr. Shea complained of chest tightness. Dr. Arenson believed that all of Mr. Shea's symptoms, including chest tightness, were caused by hyperventilation brought on by anxiety. Although the symptoms were serious enough to cause two hospitalizations and a dozen visits to his doctor in the summer of 1992, Dr. Arenson did not think the anxiety was serious enough to be treated by or to merit a referral to a psychologist. He prescribed a mild tranquilizer, which Mr. Shea did not take. Dr. Arenson denied knowing that Mr. Shea had requested a referral to a cardiologist. App. 381-99.

Mr. Shea stayed away from the Clinic until February 1, 1993, when he complained of "heartburn." Dr. Arenson noted Mr. Shea's elevated cholesterol and family history of heart disease. Dr. Arenson stated that he had no reason to be concerned about heart disease on the part of Mr. Shea in February 1993. Like Dr. Esensten, he had ruled out heart disease. App. 392-99.

Mr. Shea died the next month, after experiencing chest pain in his office in Bloomington, Minnesota on March 5, 1993. In reliance on his doctors' advice, he did not seek out emergency care. Instead, he got in his car an drove across town to the Clinic, passing at least two hospital emergency rooms on the way. He stopped several blocks from the Clinic, executed a parallel park, and then died in his car. App. 46-47; U.S. District Court, D. Minn., Case No. 96-CV-406, Docket No. 158, Ex. A at pp. 300008-15 (autopsy records).

The autopsy revealed 80-85% blockage in the left anterior descending coronary artery and 50-60% blockage in the right coronary artery. The final diagnosis was that Mr. Shea had suffered from arteriosclerotic heart disease sufficiently long-standing to have become partially calcified and had experienced sudden cardiac death. Case No. 96-CV-406, Docket No. 158, Ex. A at pp 300008-15.

B. UNDISCLOSED MANAGED CARE INCENTIVES.

Mr. Shea participated in his employer's group health plan (the "Plan"), which, in turn, offered coverage under the "Share" HMO "plan." Share later became known as "Medica Primary." Mr. Shea accepted this coverage for himself and his family from 1989 through the date of his death on March 5, 1993. Mrs. Shea continued coverage for a brief time thereafter. App. 50-51.

The Share/Medica Primary coverage required Mr. Shea to select a "primary care office" from a list that included the Defendant Clinic. Mr. Shea selected the Clinic, which thereby assumed responsibility for coordinating all covered health services. Specialist care required a written referral authorization from the Clinic. Apart from the premiums paid in advance for this coverage, and the $10 to $15 co-payments made by the patient, there was no additional patient charge for visits to the Clinic or to referred specialists. Similarly, drug prescriptions were covered unless otherwise specifically excluded, subject to a $ 9.00 per prescription unit co-pay. Hospital services were also broadly covered, if "ordered, provided or arranged under the direction of your primary care office." The charges to the patient were limited to a $40 per visit co-pay for hospital emergency room services. Case No. 94-CV-1173, Docket No. 10 (Zwak Affidavit, which, in turn, attaches Medica Primary Certificate of Coverage).

The relationship between Medica and the doctors who would provide care to Plan participant was tersely described in booklets distributed by Medica on behalf of the Plan as the subject of a "contract", whose terms are not disclosed. *Id.*, Medica Primary Certificate at p. 49. Medica disclosed nothing about the underlying contracts it negotiated with the providers. So far as the patients knew, their family doctors were paid for services rendered, had no financial interest which conflicted with their "sole responsibility" for providing

health care to the patients, and had no responsibility for paying for their needed specialist care, expensive drug care, or hospital charges. *Id.*

Unbeknownst to Mr. Shea, the Clinic had executed a contract with Medica that created a series of financial incentives and disincentives that potentially conflicted with the Clinic's duty to refer the patient for needed specialist care, drug therapy, and hospital care. App. 50-53.

The Clinic executed its first contract with Share in November of 1988. That contract was entitled "Two Pool Primary Care Provider Participation Agreement" (hereafter, the "Pool Agreement"). App. 400-28. A similar agreement was executed in 1991, and was assigned to Medica when that entity was created by the merger between Share and Physicians Health Plan on or about the period 1991-92. Case No. 96-CV-406, Docket No. 108 (Third Amended Complaint ¶ 65); Docket No. 116 (Medica Answer ¶ 65). Pursuant to the Pool Agreement, and the master contract signed between Share and the Plan, Seagate forwarded premium payments to Share (later, Medica) for each plan participant who elected to enroll in the Share HMO, later known as the Medica Primary HMO. U.S. District Court, D. Minn., Case No. 94-CV-1173, Docket No. 10 (Zwak Affidavit, attaching master contract between the Plan and Medica); App. 400-28; U.S. District Court, D. Minn., Case No. 96-CV-406, Docket No. 158, Ex. I (1991 Pool Agreement).

Share (later Medica) allocated to administrative costs 15% of the premium payments forwarded by the Plan for each enrolled participant. Then it deposited into a "PCPCF" fund 49% of the premium dollars of each Plan participant who selected the Clinic as his or her primary care office. This "PCPCF" fund was used to pay the Clinic for the primary care provided to those Plan participants and beneficiaries. Regardless of whether any Plan members were seen at the Clinic in any given month, the amount of premium in the PCPCF fund, less deductions to be described below, was paid

to the Clinic at the end of the month. Similarly, if Plan members visited the Clinic each day of the month, the same amount of premium in the PCPCF fund, less deductions to be described below, was paid to the Clinic at the end of the month. App. 400-27 (1988 Pool Agreement); App. 201-39 (explanation of pool agreement at Cooney deposition). This is known in the industry as "capitation", which has been defined as follows:

> **Capitation** A monthly fixed payment to your health care provider regardless of how much care is provided. This payment is usually set as a per member per month (PMPM) dollar amount. Capitation payments for different medical and surgical specialties vary widely.

Michael E. Cafferky, MANAGED CARE & YOU 182 (1995).

Thus, the Clinic would generally be paid a fixed amount per member per month regardless of how many times the member was seen at the Clinic. The reason the amount actually paid per month would vary was that money would be deducted from the PCPCF fund each month and be used to pay two very important items. ***First***, the fees of specialists to whom the Clinic referred Plan members were paid out of the PCPCF fund. ***Second***, the cost of drugs (less co-pay) prescribed by the Clinic was paid out of the PCPCF fund. Therefore, the more referrals, the more the monthly deduction from the PCPCF fund, the less there is left over for the Clinic at the end of the month. Similarly, the more drugs prescribed for Plan members, the less the money left over for the Clinic at month end.

The 36 cents of each premium dollar that remained after 15 cents was paid to Medica and after 49 cents was paid into the PCPCF fund was deposited into the ICF fund. This fund

was used to pay hospital charges. This would include the hospital room charges, surgical costs, and costs of certain outpatient procedures performed at hospitals and specialized clinics that were defined to be inpatient costs for the purposes of the ICF fund (e.g., blood products, psychiatry, dental, chemical dependency, dialysis, same day surgery). App. 419; App. 218-27 (explaining Two Pool Agreement).

The ICF fund entailed a higher level of upside and downside risk than did the PCPCF fund. Unlike the PCPCF fund, the Clinic did have to cover a portion – 50% – of any year-end deficit in the ICF fund. If too many Medica/Share patients were hospitalized, then the Clinic could be put in the position of paying for tens of thousands of dollars or even hundreds of thousands of dollars for its one-half portion of the resulting deficit. On the bright side, the Clinic would receive 65% of any surplus left over in the ICF fund. Medica would receive the remaining 35%. App. 218-27.

C. THE MATERIALITY OF DISCLOSURE.

Unfortunately, neither Dr. Esensten, Dr. Arenson, nor the Clinic ever disclosed to Mr. Shea, at any level of specificity or generality, this governing web of managed care incentives against specialist care. Mrs. Shea offered to prove that had her husband known of the conflict, he would not have so uncritically relied on his doctors' advice against seeking a specialist, and he would have sought out on his own the cardiology consult that would have saved his life. App. 52 (¶ 82 of verified complaint). In short, the nondisclosure was highly material. Materiality in this sense is in the eyes of the patient. Mrs. Shea's expert, Dr. Siegler, opined that the conflict of interests was material from the ***patient's*** perspective. Regardless of whether the incentives can be shown to have actually affected medical judgment, their disclosure was necessary for Mr. Shea to make his own judgment as to his own comfort level with continuing to treat

with the doctor or to rely on his advice. The disclosure was a necessary part of informed consent. App. 60-67.

For the purposes of establishing the grossness of the violation, measuring the amount of damages, and putting the disclosure obligation into its proper context, it is further relevant to consider the ***doctors'*** perspective as well. Mrs. Shea offered to prove that the incentives were a matter of material, grave, and continuing concern to the doctors and their Clinic and affected their medical judgment. In particular: (1) the incentives had a direct and significant effect of the bottom line of the Clinic and doctors; (2) the doctors were therefore informed as to whether a patient in question was a Medica patient; and (3) the incentives changed the way the doctors treated those patients.

It should be noted in this respect that the Petitioner Doctors themselves questioned the negative effect as well as the ethics of the Share/Medica incentives. At an August 10, 1988 Clinic meeting, Petitioner Dr. Arenson himself made it very clear that managed care incentives would have an unconscionable effect on the doctors' ability to prescribe necessary care. The minutes of that meeting include the following memorialization:

> SHARE: Dr Arenson was present at the meeting to voice his opinion and philosophy relative to capitated health plans and Share in particular. He stated that it was not possible, in his opinion, to give patients the appropriate level of care that they needed in many cases. He also stated that the severe financial risk is more than he is willing to accept as a physician.

App. 482.[1]

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[1] The Eighth Circuit declined to consider this proffer of evidence because the facts came to light after the District Court had granted the partial summary judgment at issue. This Court may elect to consider such

D. THE ETHICAL AND PROFESSIONAL MANDATE TO DISCLOSE.

Dr. Mark Siegler, the director of the Center for Clinical Medical Ethics at the University of Chicago and a practicing clinician, submitted an affidavit finding that the standard of professional care required doctors who entered into this kind of managed care contract to disclose the incentives against referrals created by that contract. App. 60-67. That disclosure would include:

> [A] disclaimer that under the HMO contract, the clinic's bonus would be increased by not referring patients to specialists and that if too many patients were referred to specialists by the clinic, the clinic may be forced to pay a penalty to the HMO or capitated plan. Absent such disclosures, the reasonable patient is not in a position to make an informed and prudent choice about his health care.

App. 65. Dr. Siegler further opined that the clinician had an ***ethical*** duty in such circumstances "to disclose to the patient the clinician's financial stake in the referral decision." App. 66.

The only other medical ethicist retained in this matter, Dr. Allen, Fairview's expert, ***agreed*** with the general principal that in some circumstances, a doctor must disclose a financial incentive that may affect medical judgment. To be sure, Dr. Allen would find disclosure appropriate only in an "extreme"

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evidence, as well as the other evidence stricken by the Eighth Circuit, pursuant to its prerogative to scour the record to find alternative bases on which to affirm the result below.

case of "undue influence" -- and he did not view the present case as "extreme."

Q. Dr. Allen, would you agree that if a financial incentive could affect the judgment of a physician, that that financial incentive must be disclosed to the patient?

****

A. I disagree.

Q. And why do you disagree, Dr. Allen, with that statement?

A. I think that -- I can conceive -- I can certainly conceive of an extreme instance where a physician may have a direct -- a very direct incentive to refer a patient to a specific pharmaceutical company or for a specific product or whatever where he's incented to and will benefit from that referral, however, as a general rule, I don't believe that physicians have an obligation to disclose any of the contractual relationships with which they have with vendors or with payers. And specifically related to this case, I do not see that there is any significant amount of undue influence on the physicians practicing in this clinic such that they should have felt an obligation to disclose the nature of their relationship with the health plan to the patients at any time.

App. 309.

Whether the present circumstances required disclosure, as opined by Dr. Siegler, or whether they were insufficiently compelling to require disclosure, as opined by Dr. Allen, presented an issue of fact for trial. Both experts agree that there are certain professional and ethical duties requiring affirmative disclosure of financial incentives.

The Second Amended Complaint included the nondisclosure theory at Count Three, entitled "Fraud and Negligent Misrepresentation as against Defendants Esensten, Arenson, and the Clinic." App. 124-26. The count alleged that the governing standard of professional care required the disclosure; that had the disclosure been made, Mr. Shea would have sought out on his own the cardiology consult that would have saved his life; and that the doctors and Clinic were therefore liable for compensatory damages. Count Five alleged the right to punitive damages by reason of "deliberate disregard for the rights and safety of Pat Shea" in not making the required disclosures. App. 128-29.

CONCLUSION

For the foregoing reasons, Respondent Mrs. Shea respectfully requests that this Honorable Court deny the petition.

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Respectfully Submitted,

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